STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315009	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Runnells Center for Rehabilitation & Healthcare	40 Watchung Way Berkeley Heights, NJ 07922

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Complaint # 2723777 Based on interviews and record review it was determined that the facility failed to allow a resident with an infectious diagnosis that required Enhanced Barrier Precautions to return after being hospitalized despite the facility's ability to provide that care. This deficient practice was identified for 1 of 2 residents (Resident #2) reviewed for discharges.This deficient practice was evidenced by the following:According to Resident #2's admission Record (AR), the resident was admitted with diagnoses including but not limited to: compartment syndrome (increased pressure in an area of the body that compromises blood flow and tissue function), unspecified, subsequent encounter; paraplegia (impairment or loss of motor and sensory function in the lower half of the body), unspecified; muscle weakness (generalized); and need for assistance with personal care. According to the Minimum Data Set (MDS), an assessment tool dated 12/27/2025, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Further review of the MDS revealed that Resident #2 was frequently incontinent of bowel and had a urinary catheter. Review of a Progress Note (PN) dated 12/30/2025 at 4:47 PM, revealed that Resident #2 was transferred from the facility to an acute care hospital due to altered mental status, hypotension (low blood pressure), and diarrhea. A PN dated 12/31/2025 at 2:30 AM, revealed that Resident #2 was admitted to the hospital for septic shock (a life-threatening, advanced stage of sepsis caused by severe infection, leading to critically low blood pressure, dangerous circulatory, cellular and metabolic dysfunction, and multi-organ failure). An interview was conducted with the Infection Preventionist (IP) on 01/27/2026 at 2:37 PM. The IP stated that he was not involved in decisions about re-admitting Resident #2 because the resident had negative cultures for candida auris (CA). The IP stated that as far he knew, the facility had the ability to care for residents with CA. The IP stated that CA required contact isolation and the facility had adequate personal protective equipment (PPE) and the staff was educated on putting on and removing it. An interview was conducted with the Director of Nursing (DON) on 01/27/2026 at 3:06 PM. The DON stated that the facility was notified that Resident #2 was positive for CA on 01/15/2025 or 01/16/2025. The DON stated, We are not a C. Auris facility, and that this was based on an internal facility document. The DON further stated, C. Auris is highly contagious, that is why we do not accept it. This was a decision made by upper management. An interview was conducted with the Admissions Director (AD) on 01/27/2026 at 3:36 PM. The AD stated that during the first or second week of January, Resident #2's family member informed her that the resident was diagnosed with CA. The AD stated that she informed the resident's family member that the facility generally did not accept residents with CA. The AD stated that the facility had never accepted a resident with CA because of the facility's clinical capabilities. The AD stated that the facility's clinical capabilities was a list supplied by Corporate that states which conditions the facility can and cannot manage. The Surveyor requested to view the facility's clinical capabilities document. A follow up interview was conducted with the DON on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/27/2026 at 5:03 PM. The DON stated that the facility did not have a document which indicated that residents with CA were not to be admitted . Resident #2 was not readmitted to the facility. NJAC 8:39-4.1(31)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. Complaint #: 2728562, 2728912 Based on interviews, medical record review, and review of pertinent facility documents on 1/27/26, 2/2/26 and 2/4/26, it was determined that the facility failed to ensure that a resident was free from significant medication error. This occurred on 1/23/26, when a Licensed Practical Nurse Unit Manager (LPN/UM) incorrectly used a medication list belonging to another resident (Resident #6) to reconcile Resident #5's medications. Review of Resident #5's January 2026 Medication Administration Record (MAR) revealed incorrect medications were listed and the staff administered the wrong medications to Resident #5 on these dates as follows: -Furosemide (medication used to treat excess fluid in the body) 20 mg tablet daily (Administered on 1/24/26, 1/25/26, and 1/26/26).-Lithium Carbonate Extended Release (a mood stabilizer used to treat bipolar disorder) 450 mg tablet daily (Administered on 1/24/26, 1/25/26, and 1/26/26).-Trazodone (an antidepressant/anxiety) 100 mg tablet at bedtime (Administered on 1/23/26, 1/24/26, and 1/25/26).-Clonazepam (treats seizure disorder) 0.5 mg twice daily (Administered on 1/23/26, 1/24/26, 1/25/26, and 1/26/26).-Risperidone (antipsychotic medication) 3 mg tablet twice daily (Administered on 1/23/26, 1/24/26, 1/25/26, and 1/26/26).Resident #5's Universal Transfer Form (UTF) dated 1/26/26 at 2:20 PM, included Resident #5 was transferred to the hospital for further evaluation for [Altered Mental Status]. The facility's failure to ensure that a resident was free from significant medication error placed Resident #5 and all other residents at risk for serious harm, injury/or death and resulted in an IJ situation.The IJ began on 1/23/26 at 4:04 PM, when the wrong medications were transcribed onto Resident #5's MAR and administered to resident, until 1/26/26 at 1:40 PM when the facility stopped administering the wrong medications after the resident's family informed the facility that the medications on the resident's list of medications were not accurate, and also informed the facility that the resident was not completing their sentences. The facility was notified of the F760 IJ and was provided the IJ Template on 2/2/26 at 4:05 P.M. The facility submitted an acceptable Removal Plan (RP) on 2/3/26 at 12:41 PM. The survey team verified the implementation of the RP on-site on 2/4/26 at 2:01 PM.This deficient practice was identified for 1 of 3 residents reviewed (Resident #5) for medication reconciliation and was evidenced as follows:A review of the facility's policy titled Medication Regimen Reconciliation - Admission/re-admission dated 5/25/25 included Policy Statement: Medication Reconciliation Review (MRR) would be completed within 24 hours to prevent medication errors and potential resident harm. Procedure: 1. The licensed nurse will obtain, verify, and document with the attending physician the resident's current prescription and over the counter medications [.] 6. The primary purpose of MRRs is to help [the facility] maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately.A review of the facility's policy titled Identifying and Managing Medication Errors and Adverse Consequences dated 5/25/25, indicated that staff would strive to prevent medication errors.1. Resident #5 was not at the facility at the time of the survey; a closed record review was conducted and revealed the following:According to the admission Record (AR), Resident #5 was admitted to the facility with diagnoses which included but were not limited to: influenza, depression, cerebral infarction, hyperlipidemia, hypertension, and cardiac arrhythmia.A review of the Facility Reported Event (FRE) dated 1/28/26, revealed the following:On 1/26/26 at 1:40 PM, a medication error was identified following a medication review with Resident #5's Representative (RR), after the RR informed the facility that Resident #5 was not completing [their] sentences. The FRE further stated that after the MRR, the facility determined that a wrong medication list (Resident #6's list of medications) was utilized to reconcile Resident #5's medications during their admission process at the facility.A review of Resident #5's progress notes (PN) revealed an admission summary note written by Licensed (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Practical Nurse (LPN #1) on 1/23/26 at 3:17 PM, which stated that Resident #5 arrived at the facility at 1 PM and that LPN #1 conducted the admission assessment. A review of Resident #5's Medication Administration Record (MAR) for January 2026 included the following medications:-Clonazepam 0.5 mg tablet twice daily, Administered on: 1/23/26 at 5 PM, 1/24/26 at 9 AM & 5 PM, and 1/25/26 at 9 AM & 5 PM, and 1/26/26 at 9 AM.-Risperidone 3 mg tablet twice daily, Administered on: 1/23/26 at 5 PM, 1/24/26 at 9 AM & 5 PM, and 1/25/26 at 9 AM & 5 PM, and 1/26/26 at 9 AM.-Trazodone HCl 100 mg tablet at bedtime, Administered on: 1/23/26 at 9 PM, 1/24/26 at 9 PM, and 1/25/26 at 9 PM.-Furosemide 20 mg tablet daily, Administered on: 1/24/26 at 9 AM, 1/25/26 at 9 AM, and 1/26/26 at 9 AM.-Lithium Carbonate Extended Release 450 mg tablet daily, Administered on: 1/24/26 at 9 AM, 1/25/26 at 9 AM, and 1/26/26 at 9 AM.A review of Resident #5's Order Summary Report (OSR) revealed corresponding actives order dated 1/23/2026 for the above-mentioned medications. A review of Resident #5's medication list from the transferring facility did not include any of the above-mentioned medications. Further review of the medical record revealed that the above medications belonged to Resident #6 and not Resident #5.A statement dated 1/23/26, written by the Licensed Practical Nurse/Unit Manager (LPN/UM) indicated that LPN/UM reviewed Resident #5's admission packet and the medication list. The LPN/UM further stated that while transcribing the medication list that was on multiple pages, the LPN/UM failed to verify that each page was for Resident #5 which led to the entering of medications prescribed for Resident #6 into Resident #5's list. 2. Resident #6 was not at the facility at the time of the survey, and a closed record review was conducted and revealed the following:According to the AR, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: schizoaffective disorder, heart failure, and hypertension.A review of Resident #6's Medication List showed the same medications that were transcribed and administered to Resident #5, which included the following medications:-Furosemide 20 mg tablet daily-Lithium Extended Release 450 mg tablet, every twelve hours-Trazodone 100 mg tablet, at bedtime-Clonazepam 0.5 mg, twice daily-Risperidone 3 mg tablet, twice dailyDuring interview on 2/2/26 at 11:29 AM, LPN #1 stated that it was the role of the Unit Manager (UM) or the Nursing Supervisor (NS), depending on the shift, to complete the MRR, contact the physician and obtain appropriate orders. LPN #1 stated that upon the arrival of Resident #5 to the unit, LPN #1 completed the initial nursing assessment and stated that all paperwork was given to the LPN/UM. LPN #1 confirmed that the wrong medications were administered as noted in the EMR system after LPN/UM entered them into the MAR.During a joint interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 2/2/26 at 12:25 PM, the DON stated that when a resident is admitted on day shift, it was the responsibility of the UM to review the admission packet which included the resident's medication list. The DON further stated that once the packet was reviewed, the UM would notify the physician so that the orders could be obtained. DON stated that if the physician was not in the building, the UM would contact the provider (physician) through the phone. The DON stated that the UM was required to review resident's demographics, discharge summary and the medication list with the provider, so that the provider could make decisions regarding whether to continue with the plan, discontinue, and/or alter the plan at their discretion. The DON further stated that once the UM received verbal order confirmation from the provider, the UM would then enter medications into the resident's Electronic Medical Record (EMR). LNHA stated that on 1/26/26, she was informed by the facility's Infection Preventionist (IP) that Resident #5's family reviewed the resident's medication list and expressed concern because they believed that Resident #5 was not supposed to be on the medications on the list. The DON and the LNHA both stated that upon discovery of this information about wrong medications, the facility initiated an investigation immediately and determined that an (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	error was made in the medication transcription process. LNHA and the DON further stated that after speaking with the LPN/UM and review of the documentation, they determined that LPN/UM did not use the correct medication list, and that she provided inaccurate information to the provider when she obtained the verbal order for the medications.During an interview with the Medical Director (MD) on 2/2/26 at 2:43 PM, the MD stated that he was not sure what happened in this case, and that it was expected that residents should only be prescribed medications from their own lists. He further stated that he was not sure how Resident #6's paperwork wound up together with Resident #5's.During a telephone interview with the Attending Physician (AP) on 2/2/26 at 3:43 PM, the AP stated when not at the facility, a nurse will call and provide the new admission's demographics, including what medications are listed. The AP stated that he expects that the person providing the information has already confirmed that the demographics are correct prior to calling to obtain orders. The AP further stated that any mixing up of those lists could cause a danger to any resident. The AP stated not being aware of this incident until the facility called and informed them on 1/29/26.During a follow-up interview with the DON and the LNHA on 2/4/26 at 12:42 PM, the surveyor asked about a signed job description for the LPN/UM, the DON stated at the time of the incident the LPN/UM was covering as the UM as they were considering them for that position. The DON stated that the LPN/UM's current role was as a night shift Nursing Supervisor (NS). The DON provided the surveyor with a copy of the signed job description dated 3/5/25, which indicated that NS were responsible completing chart audits on all admissions and it listed steps that the NS was to take when contacting a physician for admission orders. Those steps included reconciling medications, reading back and verifying telephone orders, and transcribing the orders.The facility submitted an acceptable Removal Plan (RP) on 2/3/26 at 12:41 PM, indicating the action the facility would take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice as follows:On 1/26/26 Resident #5 was assessed and monitored for any adverse reaction including vital signs, and level of consciousness. Neurological checks were initiated and maintained until the resident was sent out for further evaluation. An investigation into the incident was also initiated and the identified LPN/UM was suspended pending the outcome of the investigation.On 1/26/26 an audit was initiated by the Director of Nursing (DON)/Designee of all new admissions from 1/23/26/ to 1/26/26. discharged medication reconciliation records for all new admissions and re-admissions from 1/23/26 to 1/26/26 to ensure accuracy, proper transcription, physician orders, and compliance with the facility's admission protocol. Re-education was initiated for licensed nursing staff on the facility's admission process, medication reconciliation requirements, nurse accountability and resident identification procedures. On 1/26/26 the DON educated licensed nursing staff on a new protocol requiring two-nurse verification for: Transcription and review of hospital discharge medication lists, and use of two resident identifiers prior to medication transcription and administration.The surveyor verified the implementation of the RP on-site on 2/4/26 at 2:01 PM and determined that the IJ for F760 was removed as of 1/26/25. NJAC 8:39-27.1(a)